

Innovating to Care for High-Need, High-Cost Patients

A REPORT FROM HFMA'S THIRD ANNUAL NATIONAL PAYMENT INNOVATION SUMMIT
SPRING 2018

Providers and health plans need to broaden their views to find and implement approaches that deliver greater value to the patient while ensuring the financial sustainability of the system.

With healthcare costs becoming increasingly prohibitive at both the national and individual levels, efforts to curtail costs while improving care quality continue to accelerate. More and more, these efforts are focused on addressing the highest-cost patients—the approximately 5 percent of the population that accounts for about 50 percent of costs.

With this imperative in mind, HFMA and Altarum presented the third annual National Payment Innovation Summit, Feb. 21-23 in Denver. The event brought together executives from leading physician practices, health plans, and delivery systems to share insights on the types of

payment and care models that are needed to support high-quality care for those who need it most.

TOPICS ADDRESSED IN THIS REPORT INCLUDE:

- New models that can address the social determinants of health
- Health plan approaches to implementing models that increase value
- A physician organization's approach to managing population health through clinical integration
- The latest research on primary care transformation efforts

UNDERSTANDING THE SOCIAL COMPLEXITY OF PATIENTS

High-cost patients not only are medically challenging, but they often present with social complexities that influence short-term and long-term outcomes.

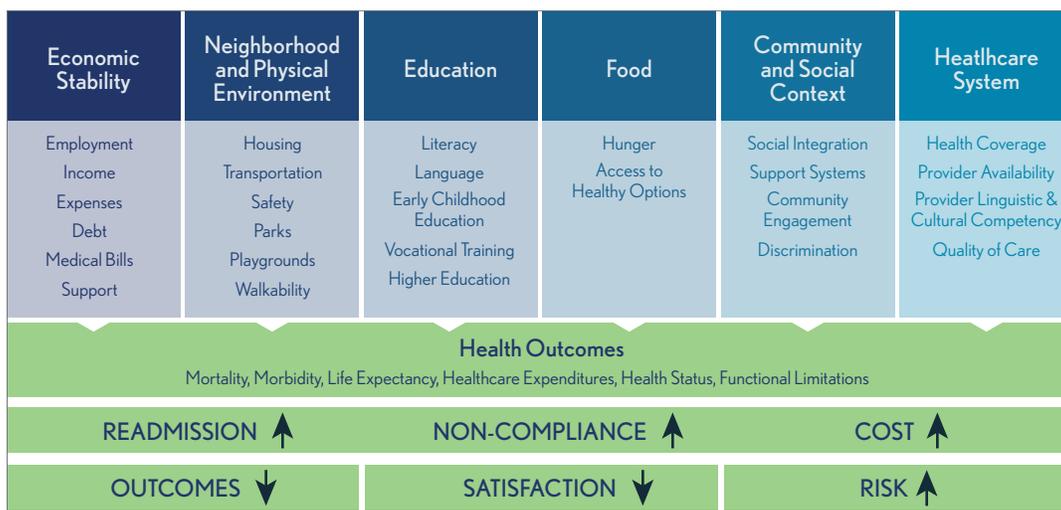
Health care’s success in bending the cost curve thus will require providers to better address both medical and social determinants of health, said Karen DeSalvo, MD, formerly acting assistant secretary for health for the U.S. Department of Health and Human Services. Creative and innovative alliances will become crucial and will likely influence success in value-based payment models.

DeSalvo, professor of internal medicine and population health at the University of Texas at Austin Dell School of Medicine, also formerly

served as national coordinator of healthcare IT for the Centers for Medicare & Medicaid Services and as New Orleans Health Commissioner.

In 2005, the cataclysmic damage to New Orleans from Hurricane Katrina offered DeSalvo an extreme example of how complex the healthcare system has become in the communities it serves. When the hurricane hit, it took the local healthcare infrastructure offline.

“I took for granted that my patient could call 911 if they were having an emergency of some sort, and we lost that capacity even if there had been a hospital [operating],” DeSalvo said. “I could tell you stories about how we pinned notes on people’s chests as they were being transported around the city to try to get care.”



SOCIAL DETERMINANTS OF HEALTH = LIFE

These social determinants are crucial factors in healthcare costs, quality, and outcomes.

Source: healthypeople2020.gov; “Healthy People/Healthy Economy: An Initiative to Make Massachusetts the National Leader in Health and Wellness,” 2015. (Data from Network for Excellence in Healthcare Innovation, 2013.) Presentation by Karen DeSalvo, MD.

“I think the long game and maybe even the short game has to do with your role and responsibility as a business leader, as an employer, and as a civic leader. We forget sometimes—we are part of the business community.”

—Karen DeSalvo, formerly acting assistant secretary for health, HHS

Clinically, physicians and first responders did not have laboratories or diagnostic testing. There was no running water. The situation forced healthcare professionals to go out onto the streets to deliver care to patients where they were. Every first responder had to talk to people and listen, she added.

“For me, as a physician, the big lesson was about how powerful it is when you release the healthcare system from the burden of regulation under which we live.” The catastrophic events served as a catalyst to redesign the complex healthcare system at the community level.

There were four keys to a redesigned system:

- 1. Expand coverage and support new value-based payment approaches.**
- 2. Digitize the healthcare system to better track and monitor care.**
- 3. Set performance goals as a community.**
- 4. Establish a foundation for primary care and mental health care.**

When DeSalvo was named national coordinator for health IT, she said, the viability of these approaches became even more apparent.

“We are entering a period in health care where we are learning about value-based payment systems, evolving them, and better understanding the best structures for success,” she said. “It’s clear that Alex Azar, secretary of the Department of Health and Human Services, will continue a value-based care agenda.”

Nearly half of Medicare beneficiaries are in a value-based care model, DeSalvo added, whether through Medicare Advantage or a new model from the Center for Medicare & Medicaid Innovation. One outcome of these models will be a focus on treating patients for all of their healthcare needs, including behavioral.

Consider that the life expectancy of U.S. citizens declined in 2016 for the second year in a row, DeSalvo noted. In addition, about 5 percent of the population accounts for about 50 percent of healthcare costs.

This small percentage has significant medical conditions, and there are often significant social factors that influence short- or long-term improvements. Those social determinants might include poverty, access to quality nutrition, and isolation (see the exhibit on page 2).

Economic strata are a major influencer of life expectancy. “If you are working in the French Quarter of New Orleans changing sheets in one of the hotels, your life expectancy is about 55 years. If you are living on the lakefront as an attorney or physician, your life expectancy is 80 years,” DeSalvo said.

“Your ZIP code is a stronger predictor of your health than your genetic code,” she added.

The reality is that health care is less important to health outcomes than are social determinants of health, she said.

“We’re not pushing any of our providers to full value if they’re not ready to assume it. We all know what happened in the 90s around that, and I don’t think anybody’s looking for a repeat.”

—Mike Funk, vice president of provider development, Humana

“Thinking about health beyond health care is where a lot of the exciting work in value-based care is moving right now,” DeSalvo said.

Three pressures are driving change within health care:

- 1. Cost containment**
- 2. Technology enabling some visibility about health outcomes**
- 3. Consumer demand to be treated/evaluated as “whole patients”**

There are many examples of how health systems are beginning to focus on social determinants as a means to improve the health of populations:

- Kaiser Permanente is leveraging data related to social determinants to identify hotspots in the community (especially where food security and transportation are big issues), and proactively working with local governments and other partners to fill needs.
- Intermountain Healthcare works with high-cost, high-need individuals by asking questions to better understand social determinants of health and execute on interventions. Questions asked include: Are you going to bed hungry? Are you worried about whether you are going to have a place to sleep?
- Children’s Mercy Kansas City has a Center for Community Connections that employs social workers onsite to address social issues.
- Other hospitals and health systems are contracting with Uber or Lyft to provide transportation when needed.

While finding transportation solutions to improve access to care is an important tactic, changing behaviors will require the combined and coordinated efforts of community leaders and civic organizations, DeSalvo said.

“I think the long game, and maybe even the short game, has to do with your role and responsibility as a business leader, as an employer, and as a civic leader. We forget this sometimes—we are part of the business community,” DeSalvo said. “In fact, [healthcare institutions and practices] are the biggest part of the business community.”

The evolution and improvement of healthcare delivery, DeSalvo added, should be focused on forging alliances to improve health for communities. “Strategic alliances will be necessary to create a culture of health,” she said.

“Because of the pressures around value-based care and increasing risk-based models, we must be a lot more aggressive about doing this in a structured and systematic way and be willing to step out on a ledge, on behalf of our patients, to begin to understand more than just their diagnoses but really what else is going on in their lives.”

A HEALTH PLAN’S APPROACH TO AIDING THE TRANSITION TO VALUE

Humana’s value-based payment footprint includes placement of 66 percent of its 3 million Medicare members in value-based programs. About 52,000 physicians in Humana’s network are in more than 1,000 “value-based relationships.”

Humana uses a percent-of-premium incentive instead of a standard per member per month (PMPM) payment.

“But again, we’re not pushing any of our providers to full value if they’re not ready to assume it,” said Mike Funk, Humana’s vice president of

The Full Schedule at the 2018 National Payment Innovation Summit

Episodic Payment Models: Avoiding the Pitfalls (Workshop)

Deborah Holzmark, Director, Dixon Hughes Goodman PLLC

Craig Tolbert, Principal, Dixon Hughes Goodman PLLC

Michael Wolford, Manager, Dixon Hughes Goodman PLLC

Commercial Market Value-Based Programs: Full Steam Ahead (Workshop)

Lili Brillstein, MPH, Director of Episodes of Care, Blue Cross Blue Shield of New Jersey

Jim Humphrey, MHA, FACHE, Operations Director, Specialty Care Collaboration, Cigna

Mark McAdoo, CEO, HealthQx

Getting to Health

Karen DeSalvo, MD, HHS Office of Inspector General and former Acting Assistant Secretary for Health

Value-Based Models, Results, and Innovation

Mike Funk, Vice President, Provider Development, Humana

Katherine Trease, Vice President, Humana

21st Century Care—A Population Health Approach to Primary Care

Rebecca Hanratty, MD, Physician and Director, General Internal Medicine, Denver Health & Hospital Authority

Tracy Johnson, PhD, MA, Director of Healthcare Reform Initiatives, Denver Health & Hospital Authority

Jeremy Long, MD, Physician and Team Leader, Intensive Outpatient Clinic, Denver Health & Hospital Authority

Managing Quality and Financial Risk at the Enterprise Level

James Heffernan, FHFMA, MBA, Senior Vice President, Finance, and Treasurer, Massachusetts General Physicians Organization

Eric Weil, MD, Chief Medical Officer, Primary Care, Partners Center for Population Health

Navigating the Population Health Corridor

James Dietsche, CFO, Bellin Health

Christopher Elfner, Director of Accountable Care Strategy, Bellin Hospital

Organizing Care Delivery Models for High-Need Patients

Don Calcagno, President, Advocate Physician Partners

The Components of Spread and Scale in the Face of Complexity

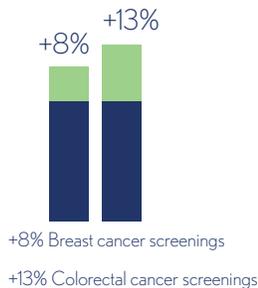
Jay Want, MD, Executive Director, Peterson Center on Health Care

Wrap-up and a Look Ahead

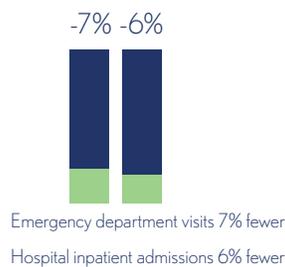
Stacey Eccleston, Director of Payment Innovation Solutions, Altarum Institute

James H. Landman, JD, PhD, Director of Healthcare Financial Policy, Perspectives and Analysis, HFMA

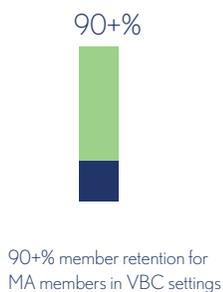
Prevention



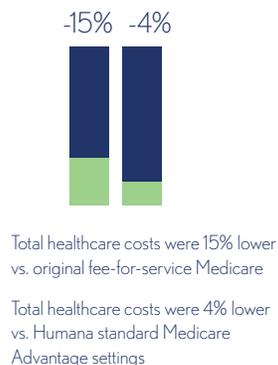
Outcomes



Quality Measures



Cost



provider development. “We all know what happened in the 90s around that, and I don’t think anybody’s looking for a repeat of that.”

Humana’s value-based programs are designed around five or six HEDIS metrics and four or five clinical measures, such as emergency department utilization and medication adherence.

In its third year of measuring the performance of its value-based contracts, Humana has seen 26 percent higher HEDIS scores for value-based program enrollees, compared with enrollees in traditional Medicare Advantage (MA) models. Value-based program enrollees also have 15 percent lower costs than enrollees whose providers receive Medicare fee-for-service rates (see the exhibit at left).

The shift also has benefited providers.

In 2016, 16 percent of Humana’s total payments went to value-based primary care. The national average is 6 percent, according to the American Academy of Family Physicians.

“When they began to move to the value-based world, they began to move toward that 16 percent number,” Funk said. “There is a redistribution of the dollars that’s taking place from what we can see.”

Obstacles persist. A recent study of hospital finance leaders highlighted challenges in the value-based transition—including a need for greater interoperability, according to 70 percent of respondents. The study was sponsored by Humana and conducted by HFMA.



26% Higher HEDIS scores for physicians in a value-based setting, compared to standard Medicare Advantage settings.



16% Share of total payments distributed by Humana to healthcare providers in 2016 that went to value-based PCPs.



15% Lower medical costs for patients treated by physicians in a Humana value-based setting, versus original fee-for-service Medicare.

BETTER OUTCOMES AND LOWER COSTS FOR HUMANA’S VALUE-BASED CARE ENROLLEES

Source: Presentation by Katherine Trease and Mike Funk, Humana.

“Quality and safety come first. It does not mean rationing care. It means people are getting the appropriate care in the appropriate places.”

– Don Calcagno, president, Advocate Physician Partners

“I really believe that interoperability is going to be a stumbling block for us if we can’t find a way through some of the issues that are there today, because I don’t think we can ultimately achieve the efficiencies without interoperability at play,” Funk said.

Despite such challenges, 74 percent reported that their organizations have achieved a positive financial result from value-based care, compared with 51 percent of executives surveyed in 2015.

Among the challenges that health system executives highlighted during the session with Humana’s executives was the financial burden presented by preauthorization requirements.

Humana is considering changing its use of preauthorization, including by ending the requirement for physicians with “more effective and efficient referral patterns,” Funk said.

“We are beginning to think along those lines, but I’ll be the first to say—and I think it’s true of our industry as a whole—we’re slow to change,” Funk said. “But those conversations are beginning to happen.”

Another key obstacle that hospital executives identified was issues around patient attribution.

“We rolled up our sleeves here probably within the last year to look at how we can do a better job of attributing, but there is no perfect science around that, so I think it really is just a matter of continuing to refine and improve,” Funk said.

Katherine Trease, vice president for payment innovation at Humana, said the insurer is increasing its focus on Medicare patient responsibility in the context of accountable care organizations and other value-based contracts.

“Some of those benefits might include the incentives on the patient side to make sure that they’re seeing their PCPs, providing them with what looks like an HSA [health savings account], like we do on the commercial side,” Trease said. “We are having those discussions. We haven’t done anything definitive yet.”

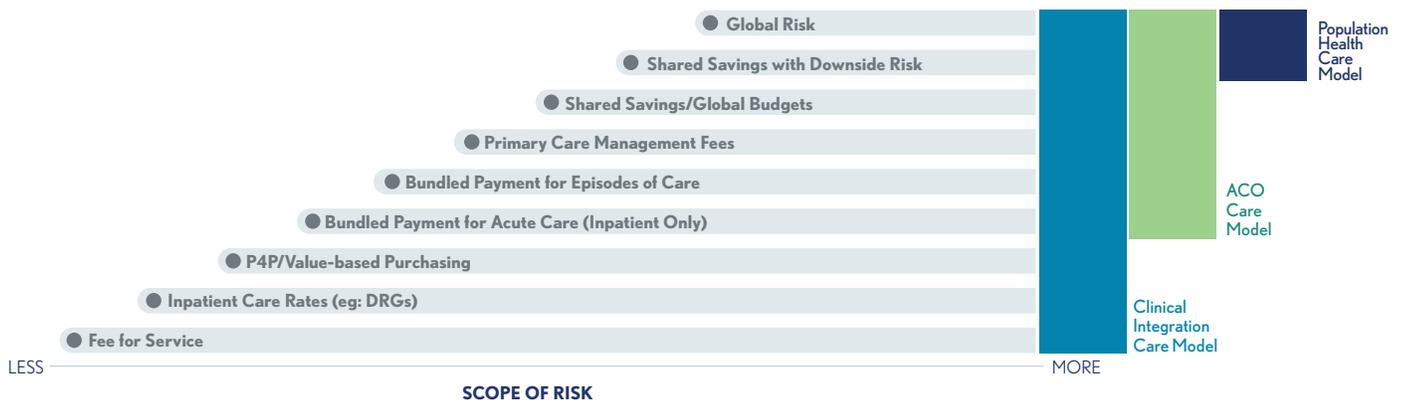
The insurer also began entering arrangements over the last two years with post-acute care management companies, which take full risk and provide care coordination and analytics for discharges to appropriate settings.

“They have shown and demonstrated quite a bit of quality,” Trease said.

In 2018, the insurer aims to launch a pilot to promote a home-based alternative to inpatient admissions for those with low-level diagnoses.

“We’re using everything, from telemedicine through home health providers, infusion, PT [physical therapy], everything, to manage that member,” Trease said.

Also in 2018, Humana is launching a hospital incentive program—based on a pilot with three systems—for its commercial insurance business. The program bases value-based payments on patient experience, patient safety, and outcomes.



EVOLVING VALUE-BASED CONTRACT STRUCTURES AT ADVOCATE PHYSICIAN PARTNERS

Source: Presentation by Don Calcagno, Advocate Physician Partners.

Efforts to address social determinants of health are accelerating, including through a pilot that provided food kits for primary care physicians with food-insecure patients. Although 15 to 18 percent of people nationwide typically test positive for a food insecurity, that rate increased to 46 percent of enrollees in the pilot.

“We attribute that to the trust that a member or a patient has in their doctor and being able to share further what their situation might be,” Trease said. Ninety percent of such enrollees accepted the food kit.

HOW A CIN ALIGNS INCENTIVES

Organizing care delivery models for high-need patients involves first coming to consensus on the definition of value-based care, said Don Calcagno, president of Advocate Physician Partners.

“Do we create enough value?” Calcagno said. “How do you know? Put it another way: How are you measuring it?” He added that if health systems don’t align on a common purpose of providing value, they’re going to have a hard time providing value-based care.

He emphasized that a good place to start on the value train is the relationship between the payer, the product, and the provider. “As you’re working with each other, is it a partnership or is it transactional?” he asked. “We all say we want it to be a partnership, but I think we also [know] it’s really hard to [create] a partnership. So, my view of what’s a partnership: It’s got to start with trust.”

Having a common purpose and trust in the partnership are the bedrocks of success in value-based care. “How do we jointly bear risk together?” he asked. “That is the only way we can produce value.”

“Thinking about that top-down—we’re doing this in order to save American health care or save the system money or whatever—nobody wants to do that. The first thing that we did when we tried to transform practices using this research was to say, ‘OK, what do you want to do?’”

—Jay Want, MD, executive director, Peterson Center on Health Care

Advocate was one of the pioneers of the clinically integrated network (CIN) in the early 2000s, but despite its early start, Calcagno describes the network as a work in progress. “We have a lot to learn,” he said, adding that Advocate has about \$6.4 billion in revenue and serves about 1.6 million patients. About a million of those patients are in a value-based model—two-thirds in models with some downside risk, including a third in globally capitated models. About 21 percent of Advocate’s revenue is in some type of risk contract. The health system employs more than 6,300 physicians and has 450 sites of care, in addition to having 35,000 aligned physicians.

During his presentation, Calcagno explored the perception of health care from the perspectives of employers and consumers. He noted that in recent years the cost of premiums went up 63 percent, whereas wages increased by 11 percent. In addition, a third of people with insurance are in high-deductible health plans that were designed to decrease utilization.

In the shift of healthcare costs to consumers, Calcagno said, studies are showing that “people just don’t get health care—even stuff they need. So, you can bend the cost curve, but you’re also not providing quality care.”

CINs can improve quality by increasing coordination. Creating clinical integration quality metrics for which every physician has a scorecard can make the process of tracking the quality of care easier for physicians because they know what they need to focus on with each patient.

Calcagno added that the measures work best when hospitals, physicians, and post-acute care providers have the exact same metrics. “It can translate the common purpose across that value chain,” he said.

“If we can get there and we’re all seeing it the same way, this is where we can begin to really make value. Quality and safety come first. It does not mean rationing care. It means people are getting the appropriate care in the appropriate places.”

He added that where health systems are challenged is in providing management and physicians with the tools to manage both fee-for-service and value-based-care income streams. Health systems are not putting the right incentives and accountability in place, he said.

Regarding how to manage risk, Calcagno used the Advocate Care Index as an example. He explained that the health system’s true north is its per member per month total expense on the index. That figure is then broken into drivers that include the emergency department (ED), hospitalization, and skilled nursing facilities (SNFs). Leaders then look at factors that they believe can move the drivers.

The health system uses Advocate-only data when examining leading indicators due to its accuracy and timeliness. One fact that leaders gleaned from their analysis is that SNF utilization in Illinois is significantly higher than the national average. That became an area of focus for driving down utilization, and the health system is now doing better than the Illinois average and is continuing to focus on lowering this metric.

Calcagno also shared how Advocate built a call center with the goal of contacting patients after discharge to improve patient satisfaction, but the health system’s scores did not improve as a result. However, the post-discharge calls helped identify safety events. Calcagno worked to change the call center model by focusing post-discharge calls on high-risk patients.

From Our Sponsor



HFMA's National Payment Innovation Summit showcased the importance of BPCI Advanced as the foundation for hospitals seeking to transform their relationships with hospital-based physicians and patients. The data, regulatory relief, and financial savings available through BPCI Advanced participation will propel hospitals further than ever on their journey to value-based care. CMS continues to push forward with bundled payment programs as a core tenet of healthcare transformation.

As a result, early data show readmissions were cut by almost 50 percent. "The stories are incredible," Calcagno said. "There's no doubt those [calls] are dropping our readmissions. There's no doubt that's going to lower our cost. There's no doubt this is the right thing to do.

"The only way I can do this, though, is if I have a risk-based contract. This is why we believe we need risk-based contracts, because the payers aren't paying enough to do this."

AN NFP'S EFFORTS TO SPREAD AND SCALE PRIMARY CARE TRANSFORMATION

Improving the value of primary care on a large scale is a daunting task. But researchers with the Peterson Center on Health Care hope they have found a viable approach by intricately researching the drivers of high-value primary care and then finding ways to inculcate those drivers at practices.

The Peterson Center, a not-for-profit dedicated to improving the quality and affordability of health care for all Americans, focuses on three main areas through its grant portfolio, said Jay Want, MD, executive director:

- Health system transformation
- Performance measurement
- Creating the environment for change (e.g., legislative and policy)

During his presentation, Want focused specifically on health system transformation. He recalled his background as president and CEO of a management services organization that encompassed about 300 primary care physicians and 600 specialists—all in risk-bearing arrangements of one kind or another.

The organization had grand plans for transitioning to global capitation, but actually implementing those plans was even more challenging than anticipated.

"We saw a lot of fatigue, burnout, lost productivity [among physicians]," Want said.

That experience gave Want an epiphany about what it takes to usher in transformation at the organizational level.

"It's about time people started talking about behavioral economics and basically what motivates people to make hard decisions," he said. "Focus on relationships, tapping into intrinsic motivators, and making adoption as simple as possible."

That approach, rather than trying to construct purely rational arguments for transitioning to value-based care, is the way to propel change at the practice level, Want said.

With this dynamic in mind, the Peterson Center hired a research group to assess what constitutes good primary care. They then sought to determine whether and how those characteristics can be instilled in practitioners at lower-performing organizations.

High-performing organizations—those in both the top quartile in quality and the bottom quartile in cost—were more likely than other organizations to engage in 10 best practices that fell into three main categories:

1. Deeper relationship with patients

- “Always on” (i.e., physicians are accessible to patients virtually around the clock)
- Conservation and conscientiousness
- “Patient complaints are gold”

2. Expanded breadth of responsibility

- In-source rather than outsource
- Stay close after referral
- Close the loop

3. Leverage the team, not physical assets

- Upshift staff roles
- Hived workstations
- Balance compensation
- Invest in people, not space and equipment

With those findings in hand, the Peterson Center sought to figure out how to persuade providers to take up those best practices. Working with three test-case physician organizations—located in New York City, suburban St. Louis, and northwestern Minnesota—they broke the best practices into 22 modules, or projects that providers can implement. Those 22 modules broke down into more than a hundred future-state functions.

For example, to forge deeper relationships with patients by being “always on,” a primary care practice could establish a future-state function in which 25 percent of patient slots would be open at the beginning of each day. “It increases the likelihood that the primary care physician will see their own patient,” Want said. “That’s better for everybody.”

The approach did not focus on grand schemes to improve health care at the macro level, but rather on what motivates individual providers.



CONNECTING INTRINSIC MOTIVATORS TO TECHNICAL CHANGES

In seeking to improve primary care practices, the Peterson Center on Healthcare began by asking its test sites what they want out of practice transformation. That allowed for the design of a process that starts with the changes the practices want to make and gives them technical fixes that help address their goals.

Source: Presentation by Jay Want, MD, Peterson Center on Healthcare.

“Thinking about that top-down—we’re doing this in order to save American health care or save the system money or whatever—nobody wants to do that,” Want said. “The first thing that we did when we tried to transform practices using this research was to say, ‘OK, what do you want to do?’”

“They want to build relationships with their patients, with the staff, with their specialists. They want to feel like they’re doing the best job possible, and they want to continue to learn.”

To achieve those goals and instill the 10 best practices, primary care providers should implement several steps, the Peterson Center found through its field research:

- Administrative and clinical leadership dyad
- Dedicated 1:1 staffing ratio (provider/care team relationship)
- Daily huddling (regular communication mechanism)

- Same-day access to own physician (patient/provider relationship)
- Ensuring all follow-up and preventive care is provided

“None of it’s easy to do,” Want said. However, “once you get a stable team, a stable population, all of this stuff is a little bit easier to do. That is what we’ve abstracted up to this point just in terms of what’s important in order to be able to make something like this work.”

Want hopes the Center’s work with the three test sites is just the start of a long journey. Once the methods are refined, the Peterson Center aims to transform 4,000 practices across the country. •

What Lies Ahead in Payment Innovation?

To wrap up the National Payment Innovation Summit, HFMA’s James H. Landman, JD, PhD, and Altarum’s Stacey Eccleston highlighted key takeaways from the three-day event. Their presentation drew on themes that emerged from the various sessions.

Words We Heard

Population health. This concept was summarized at the conference as “the need to understand your patient panel or patient population and then make adjustments to healthcare delivery according to where those patients fall in the spectrum of severity,” Eccleston said.

Value. This concept was summarized as “a payment or care-delivery model that improves quality, hopefully without raising costs; that improves cost efficiency, hopefully without damaging quality; or ideally does both,” Landman said.

Alternative sites of care. “One of the fascinating things is how relatively little we heard about hospitals over the course of the three days of presentations,” Landman said. “The role of the hospital and what’s happening with the right-care-at-the-right-place [concept] is really a significant issue.”

Social determinants of health. “We saw data that some of these items might in fact be one of the biggest contributors to the differentials that we see in the costs of health care and in the health outcomes of individuals,” Eccleston said. “We heard about new efforts for physicians, PCPs, to administer patient surveys in the clinical setting” to gauge these determinants.

Providers taking control. “This was in the context of prompting the providers to take more control in the value-based context that they’re

entering into,” Eccleston said. “We heard a caution from one individual not to just accept what’s given to you by the health plan.”

Information. “How do we take this ocean of data in the industry and distill it down to actionable information—information that is available, that is meaningful, that is timely?” Landman said. “A subsidiary question is: How much information is enough?”

Behavioral health. “This was really about how to integrate behavioral health into primary care, and that being a key in population health control overall,” Eccleston said. “We heard about shared visits with PCPs and behavioral health partners, and how the PCPs as a result of that learned how to better identify their own patients as having behavioral health issues.”

People

Physicians. “When working with physicians, really take care in what we’re asking them to do,” Landman said, referring to an anecdote in one presentation that described a situation in which physicians were asked to follow metrics that were irrelevant for some of their patients.

Other clinicians/caregivers/community partners. “Other clinicians—both internal and external to the system—we need to connect with them,” Eccleston said. “We also heard a lot about the need to connect with social services, to treat the whole patient and drop those barriers that may exist to those patients getting optimal care. How do we move the funding for those social services?”

Administrative support. “The number of FTEs on both the provider side and the health plan side that are involved in authorizations, denials, and claims management is a real issue on both sides that really needs to be figured out,” Landman said.

Patients/consumers. “Getting information out to consumers on both the price and the quality of health care with respect to different providers is important,” Eccleston said. Further, “the highest-need patients really need advocates to help guide them through the system.”

Employers. “A lot of the [payment innovation] activity is still being driven by Medicare and Medicaid,” Landman said. “Employer-sponsored insurance is seen as a key recruitment and retention benefit. There’s a real reluctance to start messing with that when you’re struggling to get employees into a position.”

Process

Evolutionary. “There’s an evolution in building the processes around these payment models,” Landman said. “The process isn’t always going to be right, right away. There are evolutionary processes within your organization as well—we did pretty well at this, let’s go up to the next level.”

Stratification/tiering/segmentation. “This is that notion of understanding your population and targeting your care to the specific needs of the individuals within the tiering,” Eccleston said. “It’s also used in predicting future costs. To make these tiers accurate, you need accurate diagnosis coding—when there are so many diagnosis codes to choose from just to indicate diabetes, how do you get the right ones that are going to trigger the right groupings?”

Strategy and implementation. “It really starts with having the vision, and then tying specific goals to that vision,” Eccleston said. “And then determining who needs to be on the team, both internal partners and community partners. Then you have to have the right infrastructure in place, IT has to be on board and in place, the administration. Any plan you implement has to be flexible so you’re able to make mid-course corrections.”

Time and timing. “Understanding that these processes take time to take hold,” Landman said. “Things are going to intervene and set you back. Just make sure you’re timing things rationally. Not everything is going to happen at once.”

Technology

Interoperability. “Even different hospitals within a system might be on different instances or different platforms,” Landman said. “The even bigger issue is external interoperability as we’re moving out to social determinants of health and behavioral health and all these different settings—to really build out interoperability across the community partners as well.”

Technology-driven data meets human insights. “Data is incredibly important, something that is potentially transforming the industry,” Landman said. “But we need to have those clinical, operational human insights into what that data means.”

Standardized metrics. “Physicians need transparency on the metrics that they’re going to be held accountable for,” Eccleston said, adding that “as physicians are in the workflow process, maybe they do need to be prompted to pick certain codes that are going to be picked up by those stratification tools or risk-standardization tools.”

The role of retail/hotspotting/predictive modeling. “We heard on the retail side of things about Big Data and, for example, the availability to see who’s buying bacon [to understand] where you need to target your coronary artery disease efforts,” Eccleston said. “The super-utilizers come in here, too. Are there geographic areas where segments of your patient population are visiting the hospital in high quantities?”

Power of combining health plan and provider knowledge. “There is real power in the ability to bring together the immense knowledge that health plans have on the actuarial side, the claims data side, etc., and the clinical knowledge that providers have,” Landman said.

Partnership

Community resources. “We heard a lot about community partnerships and community resources,” Eccleston said. “It’s key to connecting with behavioral health patients, [for them] to be able to connect with their providers and use the social services that will benefit them. To go beyond the physical care and treat the whole patient, to make sure there are no barriers to that care.”

Finding “people who think like us.” “You’re building ‘a coalition of the willing,’” Landman said. “You’re finding specialty physician groups, primary care practices, hospitals that are thinking the same way. You’re going to be much more effective in pulling those strong, dedicated players together.”

New models for health plan/provider partnerships. “One of the really interesting things from a health plan perspective,” Landman said, “was that there’s real concern with building guardrails: ‘We do not want to drive our providers out of business. We want to be comfortable that they are capable of taking on the level of risk that they want to take on.’”

Trust. “New partnerships will be tricky, so you need to develop the trust within those partnerships,” Eccleston said. “The first partnership being the plan-provider partnership. And then of course, building trust with patients. And then there are trust relationships even within the organization, from the C-suite down to those who are on the ground, and then physicians with extended caregivers.”

Frenemies. “We heard about partnerships between competitors to fill in gaps, and those partnerships have been very successful,” Eccleston said. “So just thinking outside the box.”

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HFMA would like to thank Change Healthcare, Cognizant, Optum, Remedy Partners, and SKYGEN USA for supporting the third annual National Payment Innovation Summit. The three-day event brought together a diverse group of industry leaders to discuss challenges and solutions in the effort to improve care and payment models.



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Healthcare Financial Management Association
3 Westbrook Corporate Center, Suite 600
Westchester, Illinois 60154-5700

Correspondence: resourcecenter@hfma.org

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